

DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH PROFESSIONS LICENSURE

617-727-6091

http://www.mass.gov/dph/boards/

Date Received (stamp):

Entered into the Database(Date)://					Dock	et #:		
Acknowledge	ement letter sen	t (Date):	//		Signat			
Please comple COMPLAIN		ully as possib	le. (PLEASE				ease type or print legibl	y in in
Name:								
A ddma	Last Name				First Name		M.I.	
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	City				State Zip C	Code	Evening Phone	
Best way to re	each you: DE	vening Phone	□Daytim	e Phone	□E-mail:			
COMPLAIN	T AGAINST (u	se separate f	form for ea	ch licen	sed individual)) :		
Name:								
	Last Name				First Name		M.I.	
Address:	Number	Street					Daytime Phone	
	City				State Zip C	Code Lie	eense Number/Type Cla	.SS
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	Business Ad	ldress				<u> </u>	Daytime Phone	
	City			State	Zip Code	Busi	ness License # / Type (lass
Please check	the trade or profe	ession that thi	s complaint	pertains	s to:			
Dental		Nurs	ing			Phar	macy	
Dentist			Licensed Practical				Pharmacist	
Dental Hygenist			Registered	d Nurse			Pharmacy Technician	Ī
							Drug Store	
							Warehouse Distribute	r
Nu	rsing Home	Adminis	strator		Physic	cians A	Assistant	
Per	fusionist				Respi	iratory	Care Therapis	t

events occurred. List the names of all individuals involved. Please attach additional pages if neede
(Please use a separate sheet if necessary. Please do not write in the margins.)
Additional information or materials attached □Yes □No
Γο speed up processing your complaint, please submit legible copies (not the originals) of all relative documents supporting your complaint (i.e. contracts, medical records, cancelled checks, etc.). You will receive an acknowledgement letter with the name of the investigator assigned to your case.
AUTHORIZATION FOR RELEASE OF RECORDS AND REFERRAL OF COMPLAINT
My signature to this form, or a photocopy thereof, authorizes the Department of Public Health to: (1) receive copies of all medical, dental and mental health records relating to my complaint, and (2) to refer my complaint to other appropriate law enforcement authorities to investigate and/or prosecute my complaint.
Please note that all complaints are investigated to determine their factual basis. The act of filing a complaint does not assure or imply that disciplinary action will be taken against the licensee.
attest that the information provided is true, correct and complete to the best of my knowledge.
Complainant signature Date

Briefly describe the incidents that led to your complaint and note the times and dates that

Mail this form to:
Department of Public Health
Division of Health Professions Licensure
239 Causeway St., Suite 400
Boston, MA 02114